ERIC F. O'NEILL, M.D., P.A.

Patient's Name ____
First Middle Last

Address ____
Street & Apt # City State Zip Code

Home Phone ________________ Cell Phone ________________ Other ________________

Any restrictions for contacting you? Yes No Email ________________________

Contact Restrictions (HIPAA) ________________________________

Drivers License # / State ________________________

SS# ______________ Birth date __________ Age ________ Female Male

Marital Status Single Married to: ________________ Divorced Widowed

Emergency Contact ________________________ Relationship to Patient ____________

Address ____
Street & Apt # City State Zip Code

Phone ________________________ Other ________________________

Patient's Employer ________________________________

Work Phone ________________ Ext ________ May we call you at work? Yes No

Referring Person / Physician ________________________________

Pharmacy – Name & Phone ________________________________

Authorization for Medical/Surgical Opinions, Procedures and/or Treatment:
I hereby authorize Dr. Eric F. O'Neill to administer such medications and or treatment as are necessary and such procedures as are considered to be therapeutically necessary on the basis of findings in my case. I also consent to the administrations of such anesthetics as are necessary.
I understand that all office visit charges are due and payable on the day service is rendered to me.

Signature ________________________________ **Date** ______________

Note: If Patient is a minor, under the age of 18, parent or guardian must verify and sign above.